STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11968576	**02/01/2017**
NAME OF PROVIDER OR SUPPLIER **INSPIRED LIVING AT SARASOTA**	STREET ADDRESS, CITY, STATE, ZIP CODE **1900 PHILLIPPI SHORES** **SARASOTA, FL 34231**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced Complaint survey for CCR#2016013149 and CCR #2016014399 was conducted on through at Inspired Living at Sarasota, an assisted living facility (license #12463) in Sarasota Florida.

CCR #2016013149 contained 2 allegations, of which 1 is substantiated with deficiency.

CCR #2016104399 contained 2 allegations, both of which were unsubstantiated.

The the following is a description of the deficiencies:

0028 - Resident Care - Activities of Daily Living - 58A-5.0182(4) FAC

Based on observation, five of seven resident records reviewed, and staff interviews the facility failed to provide appropriate care and services to Residents #3, #5, #6, #7, and #8 while eating in the dining .

The findings included:

1. Observation on at 12:00 p.m., showed Resident #3 sitting at a table in dining # . He was served his lunch by 12:13 p.m. He took two bites of his food. He did not eat anymore of his meal. At 12:30 p.m., a dietary staff member pushed his wheelchair closer to the table. No one offered him any assistance or encouragement to finish his meal. Resident #3 left the dining 12:48 p.m., not eating his meal. An interview was conducted with Staff C on at 1:45 p.m. She said Resident #3 needs assist with all of his Activities of Daily Living (ADLs). A review of his health assessment showed he requires supervision with eating.

2. Observation of Resident #5 on at 12:00 p.m., showed he was sitting in dining # . He was given his meal by 12:13 p.m., and he did not eat it. Dietary staff gave him dessert. He ate that. No one offered him any assistance or encouragement to eat his meal. At 12:35 p.m., a staff cut his fish and walked away offering no assistance. At 12:45 p.m., a kitchen staff asked if he was going to eat anymore lunch and Resident #5 said, "no." At that time Resident #5 got up and walked out of dining . On an interview was conducted with Staff B at 1:15 p.m. She said Resident #5 needs assistance with all of his ADLs.

3. Observation of Resident #6 at 12:05 p.m., on showed a staff feeding him with total care in dining # . Resident #6 had puréed food, scoop plate, built up utensil, and a sippy cup with handle.

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However, the staff was using these adaptive equipment. On at 1:30 p.m., an interview was conducted with Staff A. She said Resident #6 can drink on his own but if he feeds himself the "food gets everywhere." She explained dining # is for residents who are independent with dining and does not need any assistance. A review of Resident #6's health assessment dated showed he requires assistance with his eating.

4. Observation of Resident #7 on at 12:00 p.m., showed she was sitting at the dining in dining # . She was trying to eat her fish with a spoon. The fish was not cut in bite size pieces. She was spilling some of the fish on her and the floor. She started eating the fish with her fingers. There was no staff to assist her with this. Dietary staff gave her a bowl of blueberries. Resident #7 was trying to eat them with a fork. She was spilling the blueberries on her and the floor. No staff assisted her with this. She then took the bowl of blueberries to her mouth and drank/ate the blueberries. No staff intervened with this. An interview was conducted with Staff D on at 10:40 a.m. She said Resident #7 is independent with meals. A review of Resident #7's health assessment dated showed she requires supervision with her eating.

5. Observation of Resident #8 on showed he was in dining # at 12:00 p.m. He was with his private duty. The private duty staff was feeding him with total care. An interview was conducted with Resident #8's private duty on at 2:00 p.m. She said Resident #8 is able to eat his meal with assistance but she fed him a salad and if he ate this it would have been "very messy" so she fed him. A review of Resident #8's health assessment dated showed he requires supervision for his eating.

6. Residents #6 and #8 were being fed by staff when they require assistance or supervision. The facility was not encouraging them to be as independent as they can be. The facility also did not provide Residents #3, #5, and #7 with assistance with their meals when they are exhibiting they needed some type of assistance or encouragement.

Class III

0079 - Staffing Standards - Levels - 58A-5.019(3) FAC

Based on observation and staff interview, the facility failed to ensure there were enough staff to provide Residents #3, #5, and #7 assistance with their meal.

The findings included:

1. Observations were conducted on from 12:00 p,m., through 12:55 p.m., for the lunch meal in

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dining # . There were 20 residents eating in this dining one direct care facility staff. The dining served all residents their lunch by 12:13 p.m. The dining did not participate in assisting these residents with their lunch. The direct care staff fed Resident # 6. Once Resident #6 was fed by the direct care facility staff, she took him out of the dining 12:30 p.m., and did not return, leaving the rest of these residents with no staff. The other 18 residents in this dining fed themselves or not. Residents #3, #5, and #7 did not eat their lunch and there was no other staff to assist them. The other staff were in dining # assisting those residents with their lunches. There was no staff available to assist Residents #3, #5, and #7 with their meal, therefore, they went without eating their lunch.

An interview was conducted with Staff A on at 1:30 p.m. She said dining is for residents who are independent with dining and they do not need any assistance from staff to eat their meals.

Class III